NO. 56862-4-II

COURT OF APPEALS OF THE STATE OF WASHINGTON, DIVISION II

WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES,

Appellant,

v.

NORMA OCAK,

Respondent.

DEPARTMENT'S RESPONSE BRIEF

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I. INTRODUCTION

Norma Ocak, who was the legal guardian and caregiver for her legally incapacitated adult son I.O.[1], neglected I.O. by repeatedly failing to request appropriate services for him, including services Ms. Ocak was required to provide under I.O.'s plan of care. Although Ms. Ocak knew I.O. had a long history of eloping from home and knew it was unsafe for I.O. to be in the community alone, she repeatedly failed to prevent him from eloping and wandering the community by himself. This resulted in him walking into traffic, shoplifting, and spending time in jail. Ms. Ocak's actions placed I.O. in clear and present danger and resulted in his harm.

As a vulnerable adult, I.O. is protected from abandonment, abuse, financial exploitation, and neglect by the Abuse of Vulnerable Adults Act (AVA). The Department of Social and

[1] In order to protect the identity of the vulnerable adult, I.O. will only be referred to by his initials. No disrespect is intended.

Health Services (Department) is charged with investigating violations of the AVA and, in 2021, its Board of Appeals (Board) found that Ms. Ocak neglected I.O when she failed to take appropriate steps to prevent him from eloping. Because substantial evidence supports the Board's determination, this Court should affirm the Final Order concluding Ms. Ocak neglected I.O.

II. COUNTERSTATEMENT OF THE ISSUES

1. Does substantial evidence support the Board's Finding of Fact 62?

2. Did the Board correctly determine that Ms. Ocak neglected I.O. under former RCW 74.34.020(16)(b)?

3. Did the Board correctly determine that Ms. Ocak neglected I.O. under former RCW 74.34.020(16)(a)?

III. COUNTERSTATEMENT OF THE CASE

A. I.O.'s Needs and Service Plan

Norma Ocak was both the legal guardian and paid caregiver to her adult son, I.O. I Verbatim Report of

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Proceedings[2] (RP) at 25. I.O. lived with Ms. Ocak in Seattle. II RP at 65. I.O. was diagnosed with Down syndrome, obsessive-compulsive disorder, short-term and long-term memory loss, and was deemed legally incapacitated. I RP at 41-42, 150-51. He made poor decisions and was not typically aware of the consequences of his decisions. I RP at 42. During awake hours, I.O. needed onsite supervision and extensive support to prevent him from wandering and eloping from home. I RP at 43. I.O.'s Person Centered Service Plan (PCSP), which included an annual assessment and a plan for Medicaid services and goals, stated that I.O. could not be left unattended. Administrative Record (AR) at 370. I.O. also needed someone to be physically present to assist him with unfamiliar and unexpected situations. I RP at 44.

Being alone on city streets could be an unfamiliar and unexpected situation for I.O. I RP at 44. As such, I.O.'s PCSP

[2] This is the Verbatim Report of Proceedings from the Office of Administrative Hearings.

specified that I.O. required extensive assistance with locomotion outside of his immediate living environment and with getting from place to place in the community, avoiding health and safety hazards, accessing emergency services, protecting himself from exploitation, and making choices and decisions. AR at 363, 367, 384-85. I.O. did not have safety awareness and was unsafe in traffic. AR at 384-85. I.O. also required assistance with shopping because he attempted to steal from stores or argued with community members. AR at 364.

To assist I.O. with his limitations and behaviors, Ms. Ocak took care of I.O. I RP at 25. Ms. Ocak, as I.O.'s legal guardian, helped I.O. choose care services offered by the Department. I RP at 33. I.O. was eligible for 117 hours per month of personal care, and Ms. Ocak was paid to provide them. I RP at 32, 58. In addition to receiving these personal care hours, Ms. Ocak opted for I.O. to receive $2,400 per year in State Supplemental Payment. I RP at 31. Ms. Ocak used the supplemental payment to purchase items for I.O., such as soda, junk food, and

magazines. I RP at 32. I.O. would get angry and exhibit physical aggression if he did not receive these items. I RP at 32. Ms. Ocak and I.O. received the supplemental payment in lieu of other home and community based services. I RP at 31-32. Beginning in July 2019, Ms. Ocak had enrolled I.O. in mental health services through Sound Mental Health. AR at 230.

B. Attempts to Prevent I.O. From Eloping

I.O. had a long history of eloping from his home. II RP at 66; AR at 361. Ms. Ocak had told Briana Wicks, I.O.'s Department case resource manager, that more activities and another person to take him out could potentially reduce I.O.'s elopements. I RP 30. In attempts to mitigate the elopements, Ms. Wicks offered to request any services that I.O. and Ms. Ocak wanted, including respite care. I RP at 27-28. Respite care is designed to provide an intermittent break to the primary caregiver who lives with an individual they are supporting. I RP at 28. Ms. Wicks offered to request respite care for I.O. on more than one occasion. I RP at 28. During the nine years that Ms. Wicks was I.O.'s case resource

manager, Ms. Ocak never applied for respite services. I RP at 22-23, 31. In April 2019, Ms. Wicks also offered to request an exception to the rule (ETR)[3] for more personal care hours on behalf of I.O. I RP at 34, 66-67. Ms. Ocak was interested but did not provide the supporting documentation needed for Ms. Wicks to make the request. I RP at 35.

At the suggestion of Sound Mental Health, Ms. Ocak had an alarm system installed in her home to prevent I.O.'s elopements. I RP at 35; II RP at 139. I.O. did not like the loud sound of the alarms, so not only did the alarms alert Ms. Ocak that I.O. had eloped, but the sound in and of itself deterred I.O. from eloping. I RP at 35. But despite the efficacy of the alarm system in preventing I.O.'s elopements, Ms. Ocak often failed to keep the alarm system turned on because she took care of minor children, who ran in and out of the house. I RP at 36; II RP at 18. In addition to installing an alarm system, Ms. Ocak bought a GPS watch to track I.O., but

[3] An ETR is an exception to the State's policies or rules. I RP at 33-34.

I.O. often forgot to wear the watch after charging it. I RP at 140; II RP at 123. Other attempts by Ms. Ocak to handle I.O.'s elopements involved alerting the community, including local businesses, about I.O.'s elopements and calling the police when I.O. eloped. II RP at 68-69, 123.

C. I.O.'s Elopements in July and August 2019

In July and August 2019, I.O. eloped up to three days per week. I RP at 48. During these elopements, I.O. walked into traffic and consumed alcohol, which increased his chances of being hit by vehicles on the road. I RP at 113. I.O. also trespassed and shoplifted, which caused confrontations. I RP at 112. During an incident at Rite Aid, I.O. shoplifted, threw merchandise from the shelves, and became hostile. AR at 264. When he was found by the police, he was arrested. AR at 264.

I.O. was arrested and taken to King County Jail twice while eloping during this time period – once on July 17, 2019, and once on August 24, 2019. I RP at 160. In August, I.O. stayed in jail for two days after being arrested because no adult was willing to pick

him up from jail and the jail's medical and psychiatric staff determined that it was not safe to release him on the street by himself. I RP at 160-61. I.O. did not understand what was happening, where he was, or why he was there. I RP at 167. He seemed alternatively frightened and angry. I RP at 163. While I.O. was in jail, he pounded on the door and yelled for his mom. I RP at 165. Jennifer Goodwin, a personal recognizance release screener for the Seattle Municipal Court inside the King County Jail, testified that King County Jail was a dangerous place and that jail was a traumatic experience for anyone. I RP at 162. Ms. Goodwin testified that I.O. was not safe in jail. I RP at 162.

Between July 6, 2019 and August 24, 2019, the Seattle Police Department received fourteen (14) 911 calls related to I.O. eloping. I RP at 112. On August 6, 2019, members of the Seattle Police Department made an unannounced visit to Ms. Ocak's house to determine if she and I.O. needed services to minimize 911 calls. I RP at 117, 120. When they arrived at the house, Ms. Ocak

stated that she needed to check that I.O. was there and went inside to ensure that I.O. was home. I RP at 117.

D. Adult Protective Services Investigation and Procedural History

The Department's Adult Protective Services division (APS) began its investigation on August 27, 2019, pursuant to allegations of neglect from a confidential reporter. AR at 232. During its investigation, APS reviewed I.O.'s PCSP, medical information, and Seattle Police Department records. AR at 233, 235, 237-38. APS also conducted interviews with case resource manager Ms. Wicks, Ms. Ocak, Mariah Anderignis, a Seattle Police Department mental health professional, and Mariah Zeise, a Sound Mental Health provider for I.O. AR at 236. During the interviews, Ms. Zeise stated that Ms. Ocak had the best intentions but was not the best caregiver for I.O. AR at 231; II RP 25. Ms. Anderignis stated that Ms. Ocak was not able to keep I.O. safe and was "clearly overwhelmed." AR at 231.

On September 11, 2019, Natalie Frick, an APS investigator, attended a meeting with Ms. Ocak, Ms. Wicks, Ms. Zeise, and

Maureen Carroll, a crisis worker with Sound Mental Health. AR at 234. One purpose of the meeting was to address and devise solutions to I.O.'s elopements. AR at 234. At the meeting, Ms. Ocak agreed to turn on the alarm system during the day and ensure that I.O. wore a GPS watch. AR at 234-35. But these measures were not taken. II RP at 20. On September 20, 2019, Ms. Frick visited Ms. Ocak at her home and found the door of the main entrance open and the alarms turned off. II RP at 20.

Based on its investigation, APS found and notified Ms. Ocak that:

> From approximately July 6th 2019 through August 24th, 2019, a vulnerable adult under your supervision eloped at least once a week. As a person with [a] "duty of care," it is your responsibility to assure that he is safe and you are meeting his needs. Furthermore, the vulnerable adult's Service Plan negotiated with DDA states, "the vulnerable adult requires supervision during awake hours and can't be left alone." The vulnerable adult has many interactions and reported instances with the Seattle Police Department. He has a history of crossing the streets unsafely, where vehicles had to swerve or brake to avoid hitting him; has made many trips to emergency rooms due to unsafe behaviors; and has

> been the subject of Missing Person Reports. Additionally, you have been offered in-home supports to help with supervision, and you have rejected these options. Based upon your lack of supervision, you place the vulnerable adult in clear and present danger.

AR at 251. Ms. Ocak requested a hearing before the Office of Administrative Hearings. AR at 204.

A three-day hearing was held in November 2020 and an initial order entered on January 26, 2021, upholding APS' finding of neglect. AR at 103, 135-36. Ms. Ocak appealed the initial order to the Board. AR at 67. The Board affirmed the initial order and entered a Final Order concluding that Ms. Ocak had neglected I.O. under former RCW 74.34.020(16)(a) and (b). AR at 45-63. Ms. Ocak filed a petition for judicial review of the Final Order at the Thurston County Superior Court. The Thurston County Superior Court reversed the Final Order. The Court found that the Board's decision was not arbitrary or capricious but reversed the Final Order as not supported by substantial evidence.

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The Department timely appealed.

II. ARGUMENT

A. Standard of Review

The Washington Administrative Procedure Act, chapter 34.05 RCW, governs judicial review of agency actions. *Crosswhite v. Dep't of Soc. and Health Servs.*, 197 Wn. App. 539, 547, 389 P.3d 731 (2017). The agency action currently on review is a final agency order issued by the Department's Board of Appeals. *Olympic Healthcare Servs. II, LLC v. Dep't of Soc. and Health Servs.*, 175 Wn. App. 174, 181, 304 P.3d 491, 494 (2013). A final agency order may be invalidated only if one of the circumstances contemplated in RCW 34.05.570(3) is present. *Raven v. Dep't of Soc. And Health Servs.*, 177 Wn.2d 804, 816, 306 P.3d 920 (2013). The burden of demonstrating the invalidity of the agency action is on the party asserting the agency order is invalid. RCW 34.05.570(1)(a).

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When reviewing an agency order, findings of fact are reviewed under the substantial evidence test and will be upheld if supported by a sufficient quantity of evidence to persuade a fair-minded person of the order's truth or correctness. *Raven*, 177 Wn.2d at 817. Unchallenged findings of fact are verities on appeal. *Tapper v. State Employee Sec. Dep't*, 122 Wn.2d 397, 407, 858 P.2d 494 (1993). The Court will not weigh witness credibility or substitute its judgment for the agency's findings of fact. *Karanjah v. Dep't of Social and Health Servs.*, 199Wn. App. 903, 916, 401 P.3d 381 (2017). The Court reviews issues of law de novo. *Ames v. Health Dep't Med. Quality Health Assurance Comm'n*, 166 Wn.2d 255, 260, 208 P.3d 549 (2009). A court may "substitute its judgment for that of the administrative body on legal issues." *Id*. at 260-61. But courts still give "substantial weight to the agency's interpretation of the law it administers, particularly where the issue falls within the agency's expertise." *Goldsmith v. Dep't of Soc. & Health Servs.*, 169 Wn. App. 573, 584, 280 P.3d 1173 (2012). The Court can

affirm the agency action on any theory adequately supported by the administrative record. *Heidgerken v. Dep't of Nat. Res.*, 99 Wn. App. 380, 388, 993 P.2d 934 (2000).

B. Summary of the Argument

This Court should affirm the final agency order concluding that Ms. Ocak neglected I.O. The Washington State legislature created the AVA to protect vulnerable adults like I.O. from abuse, neglect, financial exploitation, and abandonment by family members, care providers, and anybody else with a relationship with the vulnerable adult. RCW 74.34.005. The Department, through APS, enforces the AVA by investigating allegations of abuse, financial exploitation, neglect, and self-neglect. WAC 388-103-0010. Under the AVA, a "vulnerable adult" includes a person found incapacitated under former RCW 11.88, or a person receiving services from an individual provider. RCW 74.34.020(21)(b), (f). And "neglect" means:

> a) a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or

> prevent physical or mental harm or pain to a vulnerable adult; or b) an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety.

RCW 74.34.020(16) (2020).

Ms. Ocak does not dispute that I.O. was a vulnerable adult during the incidents leading up to this case. Ms. Ocak alleges that the facts do not support the Department's finding that she neglected I.O. Brief of Resp. at 10. The Department disagrees. This Court should affirm the final agency order because: 1) the Board's findings of fact are verities on appeal; 2) Ms. Ocak neglected I.O. under former RCW 74.34.020(16)(b); 3) Ms. Ocak neglected I.O. under former RCW 74.34.020(16)(a); and 4) APS has no discretion when substantiating its neglect findings.

C. The Board's Findings of Fact are Verities on Appeal

Ms. Ocak does not challenge the Board's findings of fact, and thus they are verities on appeal. *See Tapper*, 122 Wn.2d at 407.

Ms. Ocak assigns error to Finding of Fact No. 62, which states:

> On September 18, 2019, Ms. Frick spoke again with Ms. Zeise. APS investigation notes reflect that Ms. Zeise reported that she had worked with I.O. since March 2019, and saw I.O. at least every 2 weeks. Ms. Zeise reported that while the Appellant had the 'best intentions' and she did not want I.O. removed from the Appellant's home, she was not sure she was the best caregiver for I.O. APS case notes reflect that Ms. Zeise reported to Ms. Frick that she would like to see the Appellant explore other living options.

Br. of Resp. at 2; AR at 25.

But Ms. Ocak fails to provide any argument or references to the relevant part of the record for her contention that the finding is incorrect. Thus, this Court should decline to review the asserted error. *See* RAP 10.3(a)(6) (stating that the Appellant's brief must contain "argument in support of the issues presented for review, together with citations to legal authority and references to relevant parts of the record"); *Cowiche Canyon Conservancy v. Bosley*, 118 Wn.2d 801, 809, 828 P.2d 549 (1992).

If this Court disagrees and reviews the finding, this Court should hold that Finding of Fact No. 62 is supported by substantial evidence. At the administrative hearing, the administrative law judge admitted a Department exhibit which showed that, during her interview with Ms. Frick, the APS investigator, Ms. Zeise, a mental health provider, stated that Ms. Ocak had the best intentions but was not the best caregiver for I.O. AR at 231. Ms. Frick confirmed during her testimony that Ms. Zeise indicated that "Norma had good intentions, that she loves her son. But she was not sure that she could provide the care that he needed." II RP 25.

The evidence in the record is sufficient to persuade a fair-minded person that while Ms. Ocak had the best intentions, Ms. Zeise was not sure if Ms. Ocak was the best caregiver. Therefore, Finding of Fact 62 is supported by substantial evidence.

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D. Ms. Ocak Neglected I.O. Under Former RCW 74.34.020(16)(b).

Ms. Ocak neglected I.O. under former RCW 74.34.020(16)(b)[4] because, as his guardian, she failed to request services appropriate to his needs and, as his caregiver, she failed to prevent him from going into the community alone or to ensure he was appropriately supervised while moving through the community. This resulted in I.O. walking into traffic, shoplifting, and spending two days in jail.

There are three elements that establish neglect under former RCW 74.34.020(16)(b): 1) An act or omission by a person with a duty of care; 2) the act or omission demonstrated a serious disregard of consequences; and 3) the disregard was of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety. *Woldemicael v. Dep't of Soc. and Health Servs.*, 19 Wn. App. 2d 178, 183-84, 494 P.3d

[4] The AVA was amended in 2021 and the definition of neglect was shifted to subsection 15 from subsection 16, effective July 1, 2022. At the time of the Board's final order, the citation for the definition of neglect was RCW 74.34.020(16).

1100 (2021); RCW 74.34.020(16)(b) (2020). This Court applies the plain language of the statute to determine whether or not the neglect of a vulnerable adult occurred. *Id*. at 183. The Department proved all three elements by a preponderance of the evidence at the administrative hearing.

1. Ms. Ocak owed a duty of care to I.O. and her actions and omissions constituted neglect.

Ms. Ocak owed a duty of care to I.O. because she was his legal guardian, paid caregiver, and because she voluntarily provided care to I.O. on a continuing basis.

A "person with a duty of care" in the context of neglect includes a guardian appointed under former chapter 11.88 RCW or a person providing the basic necessities of life to a vulnerable adult where: a) the person is employed by or on behalf of the vulnerable adult; or b) the person has voluntarily been providing the basic necessities of life to the vulnerable adult on a continuing basis. WAC 388-103-0001(14)(a), (c).

Here, Ms. Ocak was I.O.'s legal guardian and was employed on behalf of I.O. as a care provider. I RP at 22-23. As I.O.'s legal

guardian, Ms. Ocak had the authority to choose care services for I.O. I RP at 33. And, as I.O.'s paid caregiver, Ms. Ocak was responsible for caring for I.O. in accordance with his PCSP. *See* WAC 388-71-0515. I.O. was eligible for only 117 hours per month of personal care. I RP at 32. But I.O. lived with Ms. Ocak, and Ms. Ocak voluntarily provided I.O. with care and supervision outside of those 117 hours per month. I RP at 24; AR at 37; *see also* AR at 370 (PCSP stating that Ms. Ocak does not have assistance from anyone so she has to leave I.O. alone for up to two hours on a weekly basis). Thus, Ms. Ocak was a person who voluntarily provided I.O. with the basic necessities of life on a continuing basis. *See* WAC 388-103-0001(14)(c)(ii). Because Ms. Ocak was I.O.'s legal guardian, employed on behalf of I.O., and because she voluntarily provided I.O. the basic necessities of life on a continuing basis, Ms. Ocak owed a duty of care to I.O. *See* WAC 388-103-0001(14)(a), (c).

Ms. Ocak's acts or omissions constituted neglect. Ms. Ocak, as I.O.'s guardian, failed to accept appropriate services offered by

the Department. I RP at 27-28. Ms. Ocak had the authority to choose care services for I.O. I RP at 33. Case resource manager Ms. Wicks, on behalf of the Department, offered respite care to Ms. Ocak. I RP at 27-28. During the nine years that Ms. Wicks was I.O.'s case resource manager, Ms. Ocak never applied for respite services. I RP at 22-23, 31. Ms. Wicks offered to apply for an ETR for additional personal care hours for I.O. I RP at 34, 66-67. While Ms. Ocak was interested in an ETR, she did not provide the supporting documentation needed for Ms. Wicks to make the request. I RP at 35.

Respite services and additional personal care hours would have provided extra supervision of I.O. in the community. Contrary to Ms. Ocak's argument that no evidence suggests a link between possible respite services and alleviation of I.O.'s elopements, Ms. Ocak herself told Ms. Wicks that more activities and another person to take him out could potentially reduce I.O.'s elopements. I. RP 30. But in lieu of obtaining these additional services for I.O., Ms. Ocak opted to receive $2,400 a year of State

Supplemental Payment. I RP at 31. Ms. Ocak used that supplemental payment to purchase soda, junk food, and magazines for I.O. I RP at 32. Ms. Ocak failed to accept appropriate services offered by the Department.

In addition to not accepting appropriate services for I.O., Ms. Ocak, as I.O.'s caregiver, did not prevent I.O.'s elopements from their house. Ms. Ocak often failed to turn on her home alarm system. I RP at 35. I.O. did not like the loud sound of the alarm, so the sound deterred him from eloping. I RP at 35. When APS visited Ms. Ocak at her home, they found the door of the main entrance open and the alarms not turned on. II RP at 20. In addition to not keeping the alarms turned on, Ms. Ocak was not always aware of whether or not I.O. was home. I RP at 35; *see also* II RP at 18 (stating that Ms. Ocak was not always sure when I.O. eloped). When members of the Seattle Police Department made an unannounced visit to Ms. Ocak's house, Ms. Ocak stated that she needed to check that I.O. was there and went inside the house to ensure that I.O. was home. I RP at 117. Because Ms. Ocak failed

to keep her alarm system turned on and was not always aware of whether or not I.O. was home, Ms. Ocak did not prevent I.O.'s elopement from their home.

Additionally, contrary to I.O.'s PCSP, which she was required to follow, Ms. Ocak, as his caregiver, failed to provide the assistance I.O. needed when moving through the community. *See* WAC 388-71-0515 (stating that an individual provider must provide the services as outlined on the client's plan of care). I.O.'s PCSP stated that I.O. needed assistance in getting from place to place throughout the community, avoiding health and safety hazards, and learning how to access emergency services. AR at 363, 365-66. I.O. also needed extensive assistance with locomotion outside of his immediate living environment because he got lost, had poor safety awareness, and was unsafe in traffic. AR at 384-85. I.O.'s PCSP further stated that he required assistance with shopping because he would attempt to steal from stores or would argue with community members. AR at 364. But between July 6, 2019 and August 24, 2019, I.O. wandered the

community alone up to three times per week. I RP at 48; AR at 361; *see also* I RP at 112 (showing that the Seattle Police Department received fourteen (14) 911 calls relating to I.O. eloping during that period). Ms. Ocak failed to provide the assistance I.O. needed in the community.

Ms. Ocak cites *Raven v. Department of Social & Health Services* to argue that she did not neglect I.O. because she had a good faith belief that she was protecting I.O.'s autonomy by not restraining him in his home. Br. of Pet. at 7. In *Raven*, the Washington State Supreme Court held that a guardian did not neglect her ward by failing to place her in a nursing home because the guardian had made the good-faith determination that her ward, if competent, would not have wanted to be placed in a nursing home. 177 Wn.2d at 817-22. The guardian made this good-faith determination based on the ward's history of refusing placement in a nursing home when she was competent. *Id*. at 811, 821.

Raven can be distinguished from this case. There is nothing in the record before this Court to show that I.O., if competent,

would not have wanted the respite services and the ETR for additional personal care hours that the Department offered. The record does show that Ms. Ocak would have to give up the State Supplemental Payment in order to receive these services from the Department. *See* I RP at 32. And the record shows that I.O. would get angry if he did not receive the soda, junk food, and magazines, which were paid for with the supplemental payment. I RP at 32. But unlike in *Raven*, there is no evidence that, when competent, I.O. preferred the supplemental payment to the services offered by the Department. *See* 177 Wn.2d at 811, 821. The record provides no evidence at all of what I.O., if competent, would have wanted. Further, the standard in *Raven* relates only to guardians, not caregivers. 177 Wn.2d at 804-22. In this case, Ms. Ocak's duty of care stemmed from her role as both I.O.'s legal guardian as well as his caregiver. I RP at 22-23. Thus, *Raven* does not fully address Ms. Ocak's duty of care owed to I.O.

Ms. Ocak argues that the Department cited her lack of supervision as the basis of the neglect finding but that the

Department did not offer resources for supervision. Br. of Resp. at 17. Ms. Ocak contends that the resources the Department offered only involved assistance with activities of daily living. Br. of Resp. at 17. But the care hours assigned to I.O. could be used for locomotion, an activity of daily living, in the community. I RP at 68; AR at 384. And as shown above, I.O. needed extensive assistance with locomotion outside of his immediate living environment. AR at 384-85. Thus, the additional services would have provided I.O. with the assistance and supervision he needed in the community.

Ms. Ocak argues that "the agency did not identify what acts or omissions by Ms. Ocak constituted neglect. Rather than identify anything in particular, the agency simply concluded that the fact that I.O. eloped meant that Ms. Ocak failed to provide him with adequate supervision." Br. of Resp. at 12. But the Department did identify the acts or omissions by Ms. Ocak that constituted neglect: Ms. Ocak's failure as I.O.'s guardian to accept services from the Department; her failure as I.O.'s caregiver to prevent his

elopement from her house; and her failure to accompany I.O. in the community were acts or omissions under former RCW 74.34.020(16)(b). Ms. Ocak's arguments fail.

2. Ms. Ocak's acts and omissions resulted in a serious disregard of consequences to I.O.

As shown above, I.O. needed a high level of protective supervision and was very vulnerable when alone in the community. AR at 361-62. Ms. Ocak, as I.O.'s mother, guardian, and caregiver, knew I.O.'s limitations and the risks involved in his being alone in the community. AR at 361. Ms. Ocak also knew that I.O. had a long history of eloping alone from his home and that when he eloped, something could happen to him, someone could hurt him, or he could put himself in danger. II RP at 66-67; AR at 361. Ms. Ocak also had a duty to follow I.O.'s PCSP. *See* WAC 388-71-0515. Despite Ms. Ocak's knowledge of I.O.'s limitations, behaviors, and the safety risks of him eloping, and despite her duty to follow I.O.'s PCSP, I.O. eloped up to three times per week between July 6, 2019 and August 24, 2019. I RP at 48, 112, 115. Because I.O. was alone in the community when he eloped, he faced

safety and health hazards, possible exploitation, and consequences from stealing. *See* AR at 363-64, 367. Ms. Ocak's failure to accept services from the Department, to prevent I.O.'s elopement from her house, and to accompany I.O. in the community resulted in I.O. facing unsafe situations. Had Ms. Ocak accepted more personal care services from the Department, and had she accompanied I.O. in the community, he would have had more assistance navigating the community. *See* AR at 384-85. If Ms. Ocak had kept the alarm system on and known of I.O.'s whereabouts, he would have been less likely to elope at all. Ms. Ocak could have avoided the dangers that I.O. faced as a result of his behaviors and limitations. Ms. Ocak's actions and omissions resulted in a serious disregard of consequences to I.O.

Ms. Ocak relies on *Brown v. Dep't of Soc. & Health Servs.*, 190 Wn. App. 572, 590, 360 P.3d 875 (2015), to argue that the Department must show more than common law negligence to support a neglect finding. Br. of Resp. at 24. But this Court recently held in a published opinion that the *Brown* standard is

specific to child neglect cases and does not apply to the neglect of vulnerable adults under RCW 74.34. *Woldemicael*, 19 Wn.App.2d at 181-84. This Court reasoned that while a serious disregard was more than simple negligence, the relationship between a parent and minor child implicated the fundamental right to parent while the relationship between a caregiver and a vulnerable adult did not. *Id*. at 182. The *Brown* standard of negligence does not apply to this case. Rather, this Court looks to the plain language of the statute to determine whether or not neglect of a vulnerable adult occurred. *Id*. at 183.

Ms. Ocak further argues that "[t]he fact that we may look at her actions/omissions in hindsight and see how she could have done better, does not mean that her conduct constituted 'neglect.'" Br. of Resp. at 29. But this is not a situation where only hindsight shows that Ms. Ocak could have acted differently. I.O. did not elope only once; I.O. had a long history of eloping. II RP at 66; AR at 361. Knowing I.O.'s history, Ms. Ocak failed to follow through with actions that could have kept him safer.

Ms. Ocak's actions and omissions resulted in a serious disregard of consequences to I.O.

3. Ms. Ocak's disregard was of such a magnitude as to constitute a clear and present danger to I.O.'s health, welfare, or safety

During I.O.'s elopements in July and August 2019, he walked into traffic and consumed alcohol. I RP at 113. I.O. also trespassed and shoplifted, causing confrontations. I RP at 112. During an incident at Rite Aid, I.O. shoplifted, threw merchandise from the shelves, became hostile, and was thereafter arrested. AR at 264.

I.O. was arrested and taken to King County Jail twice while eloping during this time period. I RP at 160. The second time he was arrested, I.O. stayed in jail for two days because no adult was willing to pick him up from jail and the jail's medical and psychiatric staff determined that it was not safe to release him on the street by himself. I RP at 160-61.

Ms. Ocak argues that the agency "felt quite free to speculate on I.O.'s emotions" and "assumed that I.O.

experienced emotional 'trauma' as a result of his weekend stay in jail." Br. of Resp. at 18. But the record before this Court provides clear evidence of I.O.'s emotions and trauma. While he was in jail, I.O. did not understand what was happening, where he was, or why he was there. I RP at 167. He seemed alternatively frightened and angry. I RP at 163. He pounded on the door and yelled for his mom. I RP at 165. Ms. Goodwin, a personal recognizance release screener, testified that King County Jail was a dangerous place and that jail was a traumatic experience for anyone. I RP at 162. I.O. was not safe at the jail. I RP at 162. Because I.O.'s elopements caused him to face dangers from traffic, confrontations in the community, and the trauma of jail, Ms. Ocak's disregard was of such a magnitude as to constitute a clear and present danger to I.O.'s health, welfare, and safety.

Substantial evidence supports the Board of Appeals findings that Ms. Ocak owed a duty of care to I.O., and that her acts and omissions demonstrated a serious disregard of consequences of such a magnitude as to constitute a clear and

present danger to I.O.'s health, welfare, or safety. The conclusion in the Final Order that Ms. Ocak neglected I.O. under former RCW 74.34.020(16)(b) should be affirmed.

E. Ms. Ocak Neglected I.O. Under Former RCW 74.34.020(16)(a)

Ms. Ocak neglected I.O. under former RCW 74.34.020(16)(a) because as his guardian and caregiver, she repeatedly failed to accept appropriate care services, to prevent him from going into the community alone, or to ensure he was appropriately supervised while eloping in the community, resulting in I.O. walking into traffic, shoplifting, and spending two days in jail. There are two elements that, if proved, establish neglect under former RCW 74.34.020(16)(a). These elements are 1) a pattern of conduct or inaction by a person with a duty of care; 2) that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult.

In this case, substantial evidence supports the findings in the Final Order that 1) Ms. Ocak, who owed a duty of care to I.O., demonstrated a pattern of conduct or inaction; and 2) Ms.

Ocak's pattern of conduct and inaction failed to avoid or prevent physical or mental harm or pain to I.O.

1. Ms. Ocak owed a duty of care to I.O. but repeatedly failed to ensure adequate supervision in the community or to prevent I.O. from eloping

Ms. Ocak fails to provide argument that she did not demonstrate a *pattern* of conduct or inaction. Rather, Ms. Ocak simply states that the "record does not contain substantial evidence that she exhibited a "pattern of conduct or inaction." Br. of Resp. at 10. Because Ms. Ocak does not provide any argument that she did not demonstrate a pattern of conduct or inaction, this Court should decline to address this issue. RAP 10.3(a)(6); *Cowiche Canyon Conservancy*, 118 Wn.2d at 809.

If this Court disagrees and addresses this issue, it should hold that substantial evidence supported the determinations that Ms. Ocak owed a duty of care to I.O. and demonstrated a pattern of conduct or inaction. As shown above, Ms. Ocak owed a duty of care to I.O. as his legal guardian, paid caregiver, and because

she voluntarily provided I.O. the basic necessities of life on a continuing basis. *See* WAC 388-103-0001(14)(a), (c). Despite this duty of care and despite I.O.'s long history of eloping, Ms. Ocak repeatedly failed to prevent I.O. from eloping and repeatedly failed to provide I.O. with supervision in the community. Ms. Ocak often failed to turn the alarm system on in her house and was not always aware of whether or not I.O. was home. I RP at 117, 135. And Ms. Ocak, on more than one occasion, did not accept appropriate personal care services that could have allowed for more assistance to and supervision of I.O. in the community. I RP at 22-23, 31, 35; II RP at 66; AR at 361. Further, Ms. Ocak failed to accompany I.O. outside his immediate living environment, even though he needed extensive assistance in navigating the community. AR at 363, 365-66. Ms. Ocak's repeated failure to ensure adequate supervision in the community and to prevent I.O. from eloping from their house constituted a pattern of conduct or inaction.

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2. Ms. Ocak's pattern of conduct and inaction failed to avoid or prevent harm or pain to I.O.

The evidence in the record shows that between July 6, 2019 and August 24, 2019, the Seattle Police Department received fourteen (14) 911 calls related to I.O. eloping. I RP at 112, 115. During these elopements, I.O. walked into traffic and consumed alcohol, which increased his chances of being hit by vehicles on the road. I RP at 113. I.O. also trespassed and shoplifted, which caused confrontations with the public and the police. I RP at 112. I.O. was arrested twice while eloping during this time period and taken to the King County Jail. I RP at 160. While in jail, I.O. did not understand what was happening, where he was, or why he was there. I RP at 167. He seemed alternatively frightened and angry. I RP at 163. While I.O. was in jail, he pounded on the door and yelled for his mom. I RP at 165. King County Jail was dangerous and the experience was traumatic. I RP at 162.

Ms. Ocak contends that there is no evidence that her conduct resulted in a failure to avoid harm to I.O. or that there

was a "nexus" between Ms. Ocak's conduct and the harm to I.O. Br. of Resp. at 19-20. But Ms. Ocak's failure to accept services from the Department, prevent I.O.'s elopement from her house, and accompany him in the community resulted in I.O. facing these unsafe situations. Had Ms. Ocak accepted more personal care services from the Department, and had Ms. Ocak accompanied I.O. outside of his immediate living environment, I.O. would have had more assistance and supervision in navigating the community. *See* AR at 384-85. If Ms. Ocak had kept the alarm system on and known of I.O.'s whereabouts, I.O. would have been less likely to elope at all. Ms. Ocak could have avoided many of the dangers and the harm that I.O. faced.

Ms. Ocak further argues that "there is no evidence in the record that, even if these [additional] services were pursued and materialized, I.O. would have been prevented from eloping." Br. of Resp. at 34. But the evidence in the record shows that respite services and additional personal care hours could have reduced I.O.'s elopements. Ms. Ocak herself told case resource manager

Ms. Wicks that more activities and another person to take him out could potentially reduce I.O.'s elopements. I RP 30. Further, the care hours assigned to I.O. could be used for locomotion, an activity of daily living, in the community. I RP at 68; AR at 384. Thus, additional care hours would have provided I.O. with the assistance and supervision he needed in the community as well as more opportunities to go out, potentially reducing his elopements.

Ms. Ocak also contends that I.O.'s PCSP states that I.O. required round-the-clock supervision but was not paid for more than four hours per day of personal care. Br. of Resp. at 36-37. But by allowing her adult son to live with her, Ms. Ocak assumed a duty of care by voluntarily providing the basic necessities of life to I.O. on a continuing basis. WAC 388-103-0001(14)(c). And if Ms. Ocak could not provide that care, she had a duty as I.O.'s guardian to accept services that would have provided the care that I.O. needed given his wandering behaviors. Thus, Ms. Ocak's argument fails.

Substantial evidence supports the Board of Appeals findings that Ms. Ocak owed a duty of care to I.O. and that, because of her pattern of conduct or inaction, she failed to avoid or prevent physical or mental harm or pain to I.O. This Court should affirm the conclusion in the Final Order that Ms. Ocak neglected I.O. under former RCW 74.34.020(16)(a).

F. APS Has No Discretion When Making Neglect Findings.

Ms. Ocak argues that "[i]n adopting RCW 74.34 and authorizing APS to protect vulnerable adults, the Legislature could not have intended that family members like Ms. Ocak would be found to have committed neglect, when they have dedicated their lives to caring for a developmentally delayed child who, in adulthood, has developed some intractable behaviors, like wandering." Br. of Resp. at 38-39. And Ms. Ocak "asks this court not to perpetuate the fiction of an unattainable ideal that she somehow failed to meet." Br. of Resp. at 40.

A court's fundamental objective in interpreting a statute is to ascertain and carry out the legislature's intent. *Smith v. Moran,*

Windes & Wong, PLLC, 145 Wn. App. 459, 463, 187 P.3d 275 (2008). "If a statute's meaning is plain on its face, then we give effect to that plain meaning." *Id*. Under the plain meaning rule, such meaning is derived from all that the legislature has said in the statute and related statutes that disclose legislative intent about the provision in question. *Id*.

Here, the language of the statute is plain on its face that the legislature intended for APS to find neglect where there is a pattern of conduct or inaction by a person with a duty of care that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult. *See* RCW 74.34.020(16)(a) (2020). The legislature also intended APS to find neglect where an act or omission by a person with a duty of care demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety. RCW 74.34.020(16)(b) (2020). The legislature did not include authority for APS to use its discretion about when to

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make findings of neglect once the facts of the case support the definitions in former RCW 74.3.4.020(16).

Here, Ms. Ocak neglected I.O. not because she failed to meet "an unattainable ideal" but because as I.O.'s guardian and caregiver, she repeatedly failed to request appropriate services for him and failed to provide services to him that she was required to provide under his plan of care. Ms. Ocak knew that it was unsafe for I.O. to be in the community alone and her failures to prevent him from wandering the community by himself resulted in I.O. walking into traffic, shoplifting, and spending time in jail. Ms. Ocak's argument fails.

VI. CONCLUSION

Substantial evidence supports the Board's decision that Ms. Ocak neglected a vulnerable adult under both former RCW 74.34.020(16)(a) and (b) when, while acting as I.O.'s guardian and caregiver, she repeatedly failed to request appropriate services for I.O. and failed to provide services to him that she was required to provide under his plan of care. Ms. Ocak

knew that it was unsafe for I.O. to be in the community alone and her failures to prevent I.O. from wandering the community by himself resulted in I.O. walking into traffic, shoplifting, and spending time in jail. This constituted neglect both as an act or omission demonstrating a serious disregard of consequences of such a magnitude as to endanger the health, welfare, and safety of a vulnerable adult, and also as a series of acts or omissions that failed to provide the services necessary to prevent harm to a vulnerable adult. For these reasons, the Court should affirm the Final Order finding Ms. Ocak neglected I.O.

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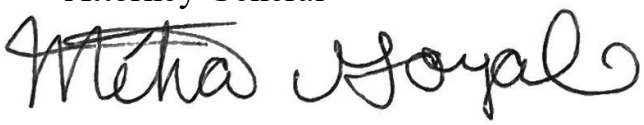
RESPECTFULLY SUBMITTED this 31st day of August, 2022.

ROBERT W. FERGUSON
Attorney General



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CERTIFICATE OF SERVICE

I certify that on the date indicated below, I caused to be served a copy of the foregoing document on all parties or their counsel of record via E-service through the Court's E-file Portal to:

Elizabeth Landry 401 2nd Avenue South, Suite 407 Seattle, WA 98104-3811	Counsel for Respondent Email: *elizabethl@nwjustice.org*

I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

EXECUTED this day of 31st August, 2022 at Tumwater, WA.

Meha Goyal, AAG

SOCIAL AND HEALTH SERVICES DIVISION, ATTORNEY GENERALS OFFICE

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